Meaningful Use Workgroup
Draft Transcript
March 22, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody and welcome to the HIT Policy Committee's Meaningful Use Workgroup. This is a Federal Advisory Committee so there will be opportunity at the end of the call for the public to make comment. A reminder, too, for workgroup members to please identify yourselves when speaking. A quick roll call, Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charlene Underwood? Latanya Sweeney? Michael Barr? James Figge?

Jim Figge – NY State DoH – Medical Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Murphy? Joe Francis?

Joseph Francis – Department of Veterans Affairs – Associate Director, Health Services Research
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Karen Trudel?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Josh Seidman?

Josh Seidman – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off?

David Lansky – Pacific Business Group on Health – President & CEO
David Lansky joined, Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning and I'll turn it back to Paul Tang.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Judy, I'm on.

M
... is also on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good morning, everyone and thank you very much for joining this call. It's going to be a full agenda as we prepare for our April 5th face-to-face meeting in Washington. We're going to start out talking about some of the RFC responses that Josh is going to summarize for us. One of the ones that's no secret to anybody is that the timing has been sometimes contentious, but there's a lot of strong sentiment in that area. In order to prepare ourselves for dealing with that in the April 5th meeting we thought it would be helpful to dedicate a considerable amount of this call's time to that area. The second half of this call will be about planning for the May 13th specialty hearing, another area where there's still unfinished work and we'd like to hear more from the field.

Okay, I think what we'll do first is any other additions to the agenda? I'd like to start off with Josh Seidman summarizing some of the themes from the responses to our RFC. The office hasn't finished the entire summary, and that will be given to us, I believe a week before our April 5th meeting. But today we'll talk a lot about some of the high-level things, and particularly on the timeline comments. Josh?

Josh Seidman – ONC
Thanks, Paul. We certainly have received quite a number of comments on the timing, which was not something that was specifically sought after. I think that there were two related issues which gets to the escalator, which was of course one of the main concepts that was put forward before stage one was

released. Which is both the steepness of the curve, how much upward movement there is in terms of raising the bar, and then the timeline at which that upward movement happens. I think that when we receive comments on timing, some of the responses obviously could be putting those two things into context, and so I think as the discussion unfolds it would make sense to consider those two things as interrelated issues.

Certainly, there were a lot of concerns about the timing in terms of providers and vendors being able to get their systems ready. So if there are new functionalities that are put in place when the final rule is released in the middle of 2012, as HHS has indicated, how much time is that going to allow for the implementation of those new functionalities. Certainly, there are other things as well, things like trying to understand stage one experience, which of course is one of the things that we're trying to do by integrating experience both from our RECs and from other sources of data. But there were also comments on the other side of the issue, in terms of the importance of raising the bar to keep the upward movement of meaningful use, both to demonstrate the impact of HITECH on quality, safety and efficiency of care, and also to help meet the broader delivery system reform goals. Certainly, there are things in meaningful use which are imperative to some of the other things that HHS is trying to do, certainly in improving the delivery system as well as ... the private sector. So there were comments about that as well.

In addition to comments on the timing, there's a lot of very valuable feedback in terms of specific items, that I won't get into now, but by next week we will have summaries of all of the objectives and the questions and so forth that the Policy Committee put out for public comment. I think that one of the things that people reacted to of course was the fact that what was presented to them was in many cases objectives that do not have fully specified measures of those objectives, and people had a lot of questions about the definition of them and needed clarification in order to express support or opposition. But there were some objectives for which there was fairly strong support indicated: patient/provider secure messaging, electronic clinical progress notes, electronic medication administration recording, recording patient preferences for communication media, and electronic prescribing of discharge prescriptions. There were other proposed measures for which there was mixed levels of support, certain in favor and certain not in favor, things like viewing and downloading longitudinal records, list of care team members, longitudinal care plans, and ... recording of advanced directives in the ambulatory setting. So again, in many cases some of the comments really were around we would need more definition in order to understand this objective and so it would be hard to express an opinion one way or the other.

I think the specific questions that the Policy Committee put out, many of them were asking for specific feedback on areas like progress notes, advanced directives, accessibility issues, things of that nature. I think that there will be many specific helpful guidance and tips and specification suggestions and things of that nature, so next week you'll see all of that and I think that will be helpful. There were a couple of policy issues. There was a question about whether to consider some other ways of achieving meaningful use in the future, whether there could be more of an outcomes approach to demonstrating meaningful use, and there was a certain amount of support for that. Again, there was a lot of question as to how that would be defined, but that was something that there seemed to be a certain amount of support for. The issue of group reporting, which was one of the questions that was asked, there was a lot of support expressed for that as well.

The last thing I will just mention, which isn't specifically related, well, it isn't specifically asked in the request for comment, but just something that this workgroup and the Policy Committee as a whole has discussed a number of times is the National Quality Strategy, which was released yesterday. I think that there are a number of things in there. The National Quality Strategy was something that was part of the Affordable Care Act and it was a report to Congress that was released yesterday that explains the department's national strategy for quality improvement in healthcare. The National Quality Strategy does provide some important guidance on things that are related. So that's something that I think makes sense for, obviously it has just come out, but as the Policy Committee thinks about where it wants to go it would be helpful to think about putting those recommendations into context of the National Quality Strategy, as well as obviously other things.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you very much, Josh. Any comments, questions for Josh?

Neil Calman – Institute for Family Health – President & Cofounder
Paul, I guess just a question about our process and our role. Josh says we're getting comments to slow down but we also got comments to make sure we keep the pace going and speed up. I guess I don't want to end up in one of those situations where we function, like in a political mode you weigh your mail on both sides and decide what we're going to do. I guess I'm trying to understand, I understand both positions and clearly have gotten similar feedback on both sides, but I guess just in terms of thinking through what our role is, the people who are on the Policy Committee are people who believe in HIT and believe in its value and have experience with it and live it. I think our natural predilection would be to continue to push things forward and see the country make progress in this area. I guess I'm trying to understand what pieces of the slowdown comments we need to pay attention to, and specifically from my point of view it would be like what are the things that are impossible and what are the things that we might be calling out that there's a predominance of negative reaction towards. But the general we're moving too fast and the vendors can't keep up kind of stuff, I don't know how to take that and I don't know what to do with those kinds of comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks for introducing the first section of the call. I think I'll postpone that a little bit so that if we get any other comments about what Josh presented, but we're going to focus on that timeline consideration, and as usual we're going to try to balance the kinds of input. So I'm going to suggest a framework for our thinking in terms of this timing question because it's easier to deal with if we separate some of the dimensions of it, and I'll try to talk about that as a way of starting the discussion. But that's exactly the tension and the quandary that we're in. We do want to move the whole country forward. Unfortunately, we're an advisory committee and the buck stops with CMS and ONC working together on this. But we want to put our best effort in terms of trying to dissect the issues and try to offer some options and recommendations to ONC and CMS.

Neil Calman – Institute for Family Health – President & Cofounder
In terms of the summary that Josh gave, I guess what I'm calling out is how that summary would come to us in its most useful fashion so that we can make intelligent decisions based on it rather than weighing the mail, that was my comment. But we can wait for that discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think we're going to do far more than weigh the mail. In the past, our track record has been that we look at the comments and weigh the substance and not the bulk weight. Any other comments before we move on to the timeline?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, we provided from the provider inventor community a lot of comments in that second area of items that Josh talked about, the areas around the care plan and longitudinal capabilities. A lot of those comments—and I think this is important for the Policy Committee—had to do with the fact that standards don't exist for some of those elements. Again, if we're going to get toward concepts of shared care plans or shared longitudinal data and those types of things, getting those standards in place are the first step. Again, I think it's something from a policy perspective that if we can say if that's what you want to do then the work needs to be done to bring together an open consensus process to agree upon what those standards should look like so that we can move forward to those in the—I don't think it's a stage two thing because there's a dependency there, especially with timelines. Again, we haven't talked about a timeline yet, but again those are the kinds of things that I think are important that we do comment on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point, Charlene. Maybe that's a good request from the ONC team that's putting together a summary. Could you include, Josh, an indication of whether standards exist to implement the functionality we've proposed, particularly the new objectives we proposed for stage two? I think that would help inform us on the issue that Charlene's calling out, which is very important.

Josh Seidman – ONC
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Anything else?

Christine Bechtel – National Partnership for Women & Families – VP
Josh, I have a question about the mixed views on view and download for the visit summary or access to the patient's health information. Could you characterize, we understand what the concerns were, and I'm not sure if they are technical because the VA has done the download capability, and I think CMS as well, but it's not in vendor systems or is it more concern focused on what was already in stage one around having access to health information for patients?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder, Christine, if we can postpone the specific discussion for April 5th, just because otherwise we'll get into all the specifics, but again, like Charlene's comment, it does say can we tease out the kinds of issues in addition to the general concepts so that we can weigh those.

Christine Bechtel – National Partnership for Women & Families – VP
That's the all-day meeting where we will—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, we're going to go through each one of these and look at them. But I think if there are comments on how can the office help us with the format of this summary they're preparing, like the details you're suggesting and what Charlene's suggesting, you know the availability of standards, that would be very instrumental in terms of helping to weigh the substance of those arguments.

Josh Seidman – ONC
Yes, and I think to highlight that, what we want to do is we want to provide you with summaries of the comments on an objective by objective basis, or in some cases it will be objective clusters, like the view and download will be combined into different pieces with different objectives that really were related to similar concepts. We'll put all those comments together for you about a week ahead of that April 5th all day meeting so that you'll have time to review those. We'll have an overview summary and then again these individual summaries for each one.

Christine Bechtel – National Partnership for Women & Families – VP
Great, that will be terrific.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. The reason for postponing it is we don't have that information in front of us and too, it will be to us a week before and so I'd appreciate obviously if everybody reviewed all that coming into the April 5th meeting. Any final comments there on the format or the kind of information you'd like to have the office bring forward for the April 5th meeting?

Let's move on to the timeline, because that is something we appreciate is one of the major concerns, and there's interest and support on both sides, but I thought I'd try to frame the discussion on timelines and start getting our feedback and pre-digest this ahead of going into April 5th. I thought it would be helpful to address some of the feasibility concerns. It's important to mention that I think, at least the ones that have been publicly available, most letters start out by continuing to endorse the goals of the meaningful use program, and I think that's really important. I think all of the groups, or at least the ones that I've seen in public, have been very supportive. They like the way it was framed, even in the statute, and the way that this faculty committee, the HIT Policy Committee, has worked to implement the spirit of the law in its meaningful use program.

I thought it would be helpful to, one, review the statutory constraints, because those are the things we have to live, short of an act of Congress. Two, to plot out the implementation timeline for a couple of different major categories. One is where we ask for new functionality in stage two, and the second is where we ask for increased thresholds. There are two very different kinds of objectives and they have very different implications on the industry. When I use the term "industry" I mean the provider community and the vendors that develop the products. Third, to outline some timing dimensions and options just to get it started as framing for a way of thinking of problems.

First, the HITECH constraints; the one, there's no incentive to anybody starting that's not meaningful using in EHR by 2014, and Josh or Karen, please correct me if I make any mistakes in this list. Second, in any case there's going to be no incentive payments after 2016. So the timing as you get started in various times before 2014, ends, your final payments come by 2016.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Paul, the Medicaid program goes until 2021.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, sorry about that. So there's a difference between Medicaid and Medicare. Medicaid goes until what again, Karen?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Until 2021.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The third piece is that once you start qualifying for meaningful use, and it would be with our so-called stage one criteria, the payments are then made by year. In other words, you continue to get payments as long as you meet the relevant criteria, not by stage. So you don't start getting payments and then you get your stage one payments and then you wait and you get your stage two payments. The payment year starts after you first qualify, so that's an important distinction. The fourth is no partial incentives, so for partial credit. The fifth is we're all very aware that incentives are front loaded, so one consequence is most people are going to try to get into the game to maximize their payment, and that's where the 2011, 2012 for outpatient, up through 2013 for the hospitals comes in.

The other corollary is the tail end, the incentives really taper down. So that's part of what drives part of our thinking as well as the administration's thinking in terms of trying to move the escalator far enough so that you want to get to the next story, appreciating that the payments towards the end of the incentive period diminishes considerably. Another reminder to us that even though the incentive, the care piece diminishes and ends by 2016 or 2021, the penalty phase does not diminish in the sense of they have to keep up with HHS' meaningful use program criteria throughout, otherwise they face the prospect of the penalty side.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Just for Medicare.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just for Medicare. I'm sorry. It is true that Medicare has the major share of this, but I apologize for not separating the two.

A couple of things on timing issues, there is the vendor development time and there is the provider implementation and training time, both of which are sizable, they're significant. Unfortunately, it has to be done in sequence, which causes an additive effect. Let me trace out for you two different implementation schemes for meaningful use with these two different scenarios. One, where we require new functionality in stage two, let's say, and one where we increase the threshold without requiring new functionality in their EHR.

First, with new functionality the final rule, we have this extensive but also really healthy public comment period and public input period, and then you finally get the final rule that affects both the criteria for qualifying for meaningful use, as well as the certification criteria. So if there's new functionality that is called out, then when they get it, the vendors, they must enhance their products to be able to incorporate this new functionality. So there's a certain amount of development time, there's a certain amount of QA time, there's a certain amount of testing time before it comes out and is available for the public to purchase.

The second part, and unfortunately it does come sequentially, is the provider must implement the new functionalities. They have to take the upgrade, they have to do what's called a build, configure it, they have to implement it, and they have to test it and they have to deploy and train the users on that. Next, there's a reporting period, and currently after stage one, after you qualify for stage one, which is a 90 day reporting period, there's a one year reporting period. So that means you have to in a sense have that new qualified EHR for an entire year before you try to apply for the next stage.

That's the sequence of events that happens when there's new functionality in the stage that the provider is trying to qualify for. If there's no new functionality, for where we're just increasing the threshold, for example, of current functionality, then you can see that we actually don't have this vendor development prelude and you go right into the provider incrementing their training and meaningful use and effective use of existing functionalities. Then you still have the reporting period, which after the first year is a full year, and then they qualify, so that helps illustrate how because of the sequential nature of this work plan or timeline the implication of having new functionality versus new thresholds of existing functionality.

Let me pause now to, one, see if CMS wants to correct anything that I've said; and then two, any questions. Let me go into just a framework for thinking about the options for creating flexibility, if we choose to do that.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I have a question to clarify something. The sequential idea seems to assume that the functionalities are not already present in some, or most, vendor systems, but just haven't been implemented by the users. I haven't looked at the list of stage two proposals, but do you have any feeling for which of them really do generally require new engineering and which ones are there but latent and not fully used?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's a good question, David, and of course it varies. There are over 200 certified EHRs now, and clearly the newer companies probably have much fewer of these new functionalities already latent and in place. Ones where there may be the functionality in place, let's say CPOE for labs or radiology, there's a whole implementation process, including the interfaces ..., so there's new work to be done .... I'm just going to take a guess that most of the new functionality that we've suggested as part of our draft probably involves new work by the vendors and it may not be a full development of a piece of functionality, but even new work by the vendor means they're going to go through that same process.

David Lansky – Pacific Business Group on Health – President & CEO
It goes back a little bit to Charlene's earlier question about standards, and I wonder if there's maybe a little bit of annotation we should collect as we ponder this issue that helps us understand the level of burden or work required, either on the functionality or the standards side, to achieve the goal that we've already identified.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's an excellent point. Josh, I wonder if there's some way for you to help us understand ideally the state of the industry, but it would be helpful to know is it a brand new functionality or is it more incremental? Is there some kind of qualitative assessment that would help address David's excellent point?

Josh Seidman – ONC

Yes, I think that's right. Obviously for the new functionalities you would anticipate that because they still need to be certified even if they're things that exist there may still be some work, but I think David's point is valid that there may be some things for which there's a certain amount of prevalence of certain functionalities already.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Would moving from medication orders to radiology orders or laboratory orders, is that a thresholding kind of thing, or is that a new certification kind of thing?

Josh Seidman – ONC
The current standards, my understanding, do actually have standards for all three.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So if they're certified, they're already certified for all three?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It may still be a lot of work for the provider and they need to contract with the vendors so we can talk about feasibility, but I just want to know on the certification side you're saying it's probably covered.

Josh Seidman – ONC
Right. On that one that is an example where, yes, there are certification standards that are already in place and anything that is certified as ... EHR would be certified for all three of those. Then you're right, we very well may have issues around the provider side, as Paul explained those two separate processes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Josh, that would be really helpful to have. If there's something that is "new" in our objective, it's already certified, that's a really key indicator for us. Thanks. Any other questions about what I've presented so far?

Let me go into some options or a way of thinking of options. These options are, just like we did before, menu was an example of a way to see if the EHR is certified to be able to do certain things, but not necessarily have the provider community have to immediately turn all of them on. So that was one example of flexibility we had in stage one. We talked about some of the options to address in timing, especially when new functionality must be developed, tested, and implemented.

One of the flexibilities from a timing point of view we had in stage one was the whole notion that you only had a 90-day reporting period. Literally, you only had to have the full implementation and installed and trained, etc., and used up to 90 days before you make a submission to qualify for stage one. After that, as explained, currently you acquire a year for every subsequent year. As a suggestion, if we went back to 90 days, for those in your third reporting year, that in a sense gives a nine-month grace period to get all the downstream things accomplished, getting installed, implemented, trained, etc., before you have to be in operation with your newly certified stage two EHR. That is one way to shift the timeline out up to nine months to help get some relief in the timing point of view.

Another kind of timing option is just to delay stage two. One of the modifications, the variants of that suggestion would be to delay either a certain amount of time, let's say 12 months. Another comment that's come in is, or delay it contingent on meeting a certain threshold in terms of the number of providers, hospitals or EPs that have accomplished stage one, anywhere from 30% to 70%. So those are a couple of ways of triggering when stage two takes place.

Now, obviously the consequence of that is we're delaying the functionality being in place precisely at the time. When I think another way to look at this is all this really does support health reform as the ACO rules start coming out, people—and I think at least in this committee and this workgroup's point of view—

you're certainly going to need an EHR. You're going to need a lot of the functionalities, especially, let's say, the exchange functionality and the care coordination functionality in order to effectively accomplish the goals of an ACO. Delaying stage two would come around and basically hurt the whole program. The other implication which we weighed heavily is that it certainly lowers the financial incentive to achieve stage two, so it's working against us. We're putting it off hoping that we give people time, yet at the same time it's going to decrease the financial incentive to do so. That's the delayed stage two option.

Another option that is around is considering the times, that's the two scenarios. One where we ask for new functionality and one where we ask for new thresholds in EHRs that already are certified to do something is if we raise the threshold without adding new functionality then we cut out a big chunk of time in the sequence that holds people up. Remember that everything that was even in menu, so even if you didn't have to implement it, your EHR, in order to be fully certified, had to be capable of doing all of the menu items.

Now, there's been some pushback in saying, well, gosh, that's a waste of time or money, but this can come back and we can use that functionality to say, hey, you already have this functionality. It's a matter of turning it on, so in a sense that does not limit moving menu to core, since they already have it in place. In this kind of option, raising the threshold without adding new functionality, there's no new development or certification on the part of the vendors, which is that sequential time up front. It does advance EHR as a platform to improve care or to conduct health reform, but it does not significantly advance Health Information Exchange, which is a major goal for stage two and ACOs and health reform kind of things. We could continue the current timing, so by increasing flexibility in terms of menus for new functionality.

Now, I'm transitioning a little bit to the discussion we're going to have on April 5th, which is how do we look at the new functionality and how can you give people more flexibility, along the same lines we did with stage one. We still have the menu approach, even though the final rule was indicating that the preference is really menus would go away, so all menus would be core from stage one and there wouldn't be any menus. But I think it's not a statutory requirement that be so, so one of the things that we can do to help relieve the overall burden to providers is to use the menu approach again. Another option we have is to pull back a little bit on the threshold.

Let me open it up now for discussion of the framework for making timing options available in terms of relieving some of that burden. So one would shorten the reporting period, which gives you a nine-month grace period; delay stage two; or raise the threshold without adding new functionality, which is saving some of the time up front. Questions, comments?

David Lansky – Pacific Business Group on Health – President & CEO
Paul, before you jump into that detail, I wonder if Josh or anyone can clarify the pace of registrations as you're observing them right now. I guess my question is, what is the consequence of not making any change? From the comments we received, apart from their substantive merit, is there a belief from ONC or anybody that leading it exactly as previously articulated and proposed will reduce the level of adoption by 5% or 60%, is it more going to affect hospitals or more affect certain types of EPs more than others? So before we try to assess alternatives, what's the consequence of making no change?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
My sense is that it's probably a little too early to try to answer that question. I also probably would defer to my colleagues at CMS since they're handling that kind of thing. I don't know, Karen, if you want to comment, or if you feel like it's really too early?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
No, I agree it's too early. We can't really tell anything from the registration numbers except that people are putting a marker in, although we are hearing very loud and clear from the hospital sector that they have serious problems with the schedule as it stands. I wouldn't assume, simply because we haven't heard the same degree of concern from the physician community, that it doesn't exist.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

I guess I would be most in favor of shortening the period. That seems to not have some of the downsides that the other two do. I am a little worried about delaying stage two. I understand the issues about not asking for new functionality, but I feel like not all the functionality that's really going to make a difference is actually included, so that if we were to drop a bunch of things I think we would miss some things that will make a difference.

Christine Bechtel – National Partnership for Women & Families – VP
I agree with David Bates. I would say a couple of things. One is, I understand the need to look again at the timing, but I'm really struggling with making any recommendation at this point because for me it depends on where we end up on the criteria. So I'm nervous, without really looking at the feedback and truly understanding what the challenges are for folks in the criteria, about making any kind of decision or recommendation at this point on which path forward to take other than to acknowledge this is an issue. We need to look at it and we need to have a really in-depth conversation about it, but in my mind it's a little backwards for me.

I would say the one thing I could do is probably take some timing options off the table at this point, but I'm not prepared to really make a recommendation. Particularly in the sense that for something like secure messaging if we understand from the comments that there is support for that but we say today, "Well, let's just make it easier by doing no new functionality." Where does that leave us? I think David is right, that stage one was supposed to be about data capture and we operated on a more constrained timeline in stage one and have pulled it off so far. I guess we don't completely know yet to what degree, but from a technical perspective, it appears that we still have products that were certified and still use standards and went through a regulatory process.

I'd rather have more information about what the criteria and the reaction to the criteria are. Then look again, having appreciated today that we are exploring options, and then look again at what timing options might be, because I'll only say one other thing, which is if, for example, we were to agree today to just raise the thresholds and let's say shorten the reporting period, that makes no sense. You can't do both, because if you give them a shorter time to do the same thing but with more people I don't think that's going to work. So until we have the criteria, I'm really hesitant to engage too much in this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me clarify, Christine. The purpose of today's discussion is to start thinking about these, and I totally agree with you that you put together the objectives with the timing together, but I don't know that we've had this kind of discussion of the various levers we have, the adoptions we have. It's just healthy to get that out, because we only have one day together and there's so much to do. I'm just trying to start dividing the work—

Christine Bechtel – National Partnership for Women & Families – VP
Let me just say one other thing and make a suggestion. It's really helpful, Paul, what you've laid out in terms of the actual statutory constraints under HITECH and what some of the options might be. I think if we can have that be part of our package for, I know we've got the arguments for and against on the two pager, but if we can have that with our package, that might be helpful. The other thing that I'm not seeing on here is whether it's realistic if we can accelerate the regulatory timeline, because the regulatory timeline does seem to me to be pretty long. Since it's not necessarily writing a rule from scratch, as CMS and ONC had to do before, I'm wondering if that timeline can be adapted and shortened so that that gives us a little bit more time to work with.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's an interesting comment, vis-à-vis the way we opened up the session I think CMS and ONC are working at lightning speed. But it's a fair comment. I don't know whether Karen or Josh want to comment on that at all. This is talking about the six-month process, the time period between when ... delivered his final recommendations to CMS, ONC and the NPRM, and then the six months from the NPRM to the final rule.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services

It may be, Paul, that we need to speed up the Policy Committee process too. I don't know. It just seems that, if I'm remembering correctly, not having a final rule until March of 2012 or sometime in the spring of 2012, that we ought to be able to do a little bit better than that if we can. It may be a Policy Committee thing or CMS or ONC. I don't know.

M
I think there are two things here. One is that obviously there is a lot of important parts to that process and it's probably hard for outsiders to understand this and we should try to do a better job of explaining that. But the other piece of it really is trying to make sure that we have a good sense of what is going on. One of the comments that came through from many people is really trying to understand what is going on with providers, both hospital side and professional side, in their implementation and in their ability to meet stage one. It's obviously a balancing act. We want to get the rule out there as fast as possible, but we also want to take into account the experience with stage one, so we're caught a little bit in that bind.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think the public comment and feedback period ... and awaiting some of the early indicators about stage one, is just a very healthy process, so it's hard to short-change any of that, but we're all trying. Any other comments?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It seems to me that the options we talked about are probably not mutually exclusive and there may be potential to use more than one of the options. On the 90-day one, again, I think that's helpful for providers. But the vendor still has to, if it's new function that's added they'll have to fit into that time window, which if it's three months probably won't happen because they have to read the rule, interpret the rule is certified, blah, blah, blah. So again, that's a real constraint in the process.

You mentioned, Paul, that you can move the stuff from menu into having to be done, and I think that is a huge step. In addition, if we look at health information exchange, many of the standards were included in stage one, but not implemented. So, for instance, for HIE we had to be able to test but we didn't have to implement. Again, I think it would fall in the same kind of discussion, where the software's there, you just have to take it another step, so we might be able to do some things in HIE. I think that we shouldn't totally discount raising the threshold because in some cases you'll be able to actually achieve some of the functionality you want. Again, I agree. We can't do this until we look at all the comments.

One of the big areas of challenge, well two areas, I think we need to consider other HHS initiatives. Most providers are going to be implementing 2013 in the same time window and I've heard a lot of concern about that, ICD-10 in the 2013 time frame, and I've heard a lot of concern about that. I think one of the biggest challenges is in the quality measure area, where until you know what those are finally you can't implement them and you can't build your workflows around them and that type of thing. If there's any ways to put those on another boundary and get those nailed down sooner, that might help.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good points.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, I guess going along with Christine, and in some ways Charlene's comment. So we're saying we can't decide now and it may be a combination, so we have to figure out how to rationally—and there may not be time to answer by June either, for that matter, just because we don't know now doesn't mean we'll know in June how to rationally offer the options to CMS. If you give CMS a pretty broad, you could do anything from don't delay to delay of ten years and you could do anything from don't opt stage one at all, to do stage 17, that's a lot of latitude. So then how do you narrow the latitude so that, well, if we're going to delay it, it should be a little stronger. If you're going to keep it the way it is, it should be a little weaker. How do we present that to CMS in a rational, usable way is something that we could decide—I don't mean decide today, but decide in the future how do you put together a plan that accounts for both the difficulty and the timing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's very helpful. I think one of the biggest things that's come out is to know what's already in place and certified, which Charlene just mentioned. Clearly HIE's really a big focus area for stage two, but more importantly a big focus area for care coordination that's needed in health reform, and she points out that we already have it in place because it had to be certified that way and we in fact had to test for it. So that's new functionality, yet ... it advanced the agenda for health reform and HIT. Having that and finding a way to present that even back to us for April 5th will be very useful. I think it can prevent new kinds of options in terms of how much "new" functionality do we need to advance the overall agenda. That's a good point. Other comments?

Marty Fattig – Nemaha County Hospital – CEO
Paul, there's been some discussion that if you certify for stage one in 2011 and on the current schedule for the implementation it's stage two that you will not be able to show that you've been using meaningful use for the entire year of 2012 and therefore it won't qualify. I think we need to discuss that and make sure we're not putting forward a plan that is one that we can't achieve.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is because of the development time and those sorts of things and the full year, right?

Marty Fattig – Nemaha County Hospital – CEO
Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's something, and somebody mentioned that these are not mutually exclusive, so that might be one of the glitches, the unintended side effect that may be correctable through a different reporting structure.

Marty Fattig – Nemaha County Hospital – CEO
Yes, I think it is correctable. It's just something we need to keep in mind.

Neil Calman – Institute for Family Health – President & Cofounder
Paul, I have a question. On the 90-day reporting period, is it possible that some of the criteria that we put forward for stage two could require 12 months reporting and other pieces could require 90 days reporting period?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think—and Karen, correct me if I'm wrong—there's no statutory requirement that would prevent it from doing that, but we all recognize that that increases the complexity for CMS.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
I would not say just for CMS. I would say it increases the complexity for the poor providers who are trying to understand what the heck it is they're supposed to do, and we're already receiving less and less questions. This program seems transparent and simple in some ways to many of us who have been dealing with it from the get-go, but it's very difficult to grasp for people who are beginning to look at it just anew and I would strongly suggest that you consider the risk of adding any more complexity to what we already have.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a fair comment. Other comments or new ideas, new options in terms of flexibility on timing or ways that we can get the data presented to us for our April 5th meeting so that we can properly understand what's truly new and what's already out there and we can work on changing the requirements with existing functionalities? Okay.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Paul, I have a thought. I'm not sure how doable this is, but I think it might be helpful to have as some background a really good sense going into that hearing what exactly the concerns of the provider community are. I know that they're able to be present, but very often they don't get to speak until the end,

is there any way that we could have a panel at the beginning where the hospitals and physicians could maybe sit down and walk us through what their concerns actually are?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Don't you think that's coming in through the comments? I thought that was the whole purpose of that and that there was—

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
I think it is, but there's no ability to have a dialogue. We're just reading what they wrote. I don't know whether it would be helpful or not. I'm just raising it as a possibility.

Christine Bechtel – National Partnership for Women & Families – VP
The challenge I think we're going to have with that is yes, but then you want to have the consumer and employer. If you look at Josh's two pager, it almost looks like you had hospitals, health systems, docs, and vendors on one side of the issue and then consumers, purchasers, plans, and HIT advocates on the other side. So if you give voice only to doctors and hospitals it's going to upset the apple cart in a big way, since it's patients paying for this whole thing.

M
I think we should rely on the written comment part and should try to have some sort of synthesis of that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And I'm not sure there's any feasible way to manage the time to accomplish already an over-committed agenda for April 5th.

Josh Seidman – ONC
I just want to raise one other thing for the workgroup to think about as it's thinking about these issues, and I think it came up as we were talking about the constraints of HITECH. We should be making sure that what we're discussing is applicable or addresses the issues of both the Medicare and the Medicaid incentive programs. I think certainly the HITECH constraints are more constraining for the Medicare program and I think that provides a lot of pressure in terms of the timeline. But I think that it's important that we do consider how these issues apply to both programs and we might want to think about also ensuring that we get input from state officials. Now we did get some of that through the public comment process from this request for comment and we can share that with you. But that's something that I think is also worth the workgroup's consideration.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fair. To the extent that you can help signal to us in your summary which ones have a special meaning, for example, with Medicaid, that would be helpful.

Josh Seidman – ONC
Will do.

Marty Fattig – Nemaha County Hospital – CEO
There was some discussion on our last call about receiving and reviewing provider surveys regarding implementation of stage one prior to our April 5th meeting. Is that moving forward?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Josh?

Josh Seidman – ONC
I'm sorry, can you repeat the question?

Marty Fattig – Nemaha County Hospital – CEO

Yes, we were talking about probably that there were several provider constituent organizations such as the American Hospital Association or the National World Health Association or the AMA that could provide data on issues regarding implementation of stage one.

Josh Seidman – ONC
I think that beginning next month we will begin to start collecting data through the regional extension center program, which will probably be the most real-time data that we'll be able to collect.

Marty Fattig – Nemaha County Hospital – CEO
Most of that data, at least in Nebraska from the regional extension center, is dealing with eligible providers rather than hospitals.

Josh Seidman – ONC
Yes, except for critical access hospitals.

Marty Fattig – Nemaha County Hospital – CEO
So if we can get some data from hospitals I think as well I think it would be helpful.

Josh Seidman – ONC
Absolutely. We are looking for other sources of input on that and certainly have begun to reach out to other folks, and any suggestions you have would be greatly appreciated.

Marty Fattig – Nemaha County Hospital – CEO
Thank you. I appreciate that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
On that one, I know Judy, who's not on our call today, is the co-chair of the Implementation Workgroup, and they did have testimony already, I think it was in January, on the implementation of HITECH stage one. So can we share that testimony with the workgroup as reading material before our meeting, because I think there was pretty concrete testimony that was there, or is there a summary of that, Judy and Liz Johnson?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, Judy Sparrow had said that she would send that around.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Judy Murphy.

Judy Sparrow – Office of the National Coordinator – Executive Director
I can get that for you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Because I think all those venues that providers, there was a panel on HIEs and a panel on physicians and a panel on hospitals, so this is pretty diverse and spirited.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any other comments before I review the work plan between now and our final proposal for stage two? So at this call we're starting the discussion about the timeline issues and some of the potential options and kinds of options that we can incorporate in our April 5th meeting. April 5th we have this face-to-face where we'll have, a week before, a summarized response including the availability of already certified functionality and the standards applicable. As well as the Medicaid implications and any special Medicaid implications of some of these criteria, and go through — it's probably too idealistic if we make it through the entire list of criteria, but that's our goal—and somehow incorporate the timeline discussions to

formulate a package that's a combination of the functionality. You might consider the menu as part of the flexibility in the functionality itself and the timing of the implementation of the functionality, particularly for new ones. So that will all wrap up together at our April 5th meeting. We'll present probably some initial thoughts. I don't think we'll go criteria by criteria, objective by objective as we do in the final presentations, but sort of high level thoughts to get feedback for the product HIT Policy Committee and we'll also update them on the specialist hearing plans.

May 2nd we'll come back together in our workgroup and discuss the feedback we got from the broader policy committee and begin revising our stage two package. It's striking me that we may need yet another call between the April 15th Policy Committee meeting and the May 11th Policy Committee meeting because I think there will still be work left over from April 5th. But on May 11th we would present our whole stage two package to the full Policy Committee and with the caveat that there may be some updating after the specialist hearing which occurs after that May 11th Policy Committee meeting. May 13th is our specialist hearing, we're going to discuss more on the planning next, and we finalize our proposal for stage two package after the May 11th Policy Committee meeting in preparation for presenting at the June 8th HIT PC meeting for approval. That's the work plan and I suspect we're going to need to add a couple of calls in there to continue the work. Comments on that, or any questions on that?

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I think the timeline on process sounds good. I was just sitting here wondering—and I don't know the answer, but maybe folks could think about in the timing context—whether there is a different methodology approach for scoring success that we ought to consider that is slightly different. That would provide some more flexibility and yet at the same time get the right functionalities in place so that we have forward progress.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's an interesting thought. Let's think about it. If people come up with ideas that are part of the whole menu approach, are there other ways of qualifying for meaningful use incentives that can help provide some relief while moving the ball forward? That's your proposal?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, that's a good thought. All right, let's move on to the second half of our call, and now we're talking about the May 13th specialty hearing. We had a specialty hearing when we were planning for stage one recommendations, and it still remains an issue, I think, both on the functionality and what's applicable I think is part of the main issue and also on the quality measurement side, and David Lansky, feel free to speak up where that's concerned. We were coming up with some panels, I think three or four panels last time, and one approach was to look at topics where we're not going specialty by specialty, because that's not possible, there are lots of specialists, but thinking about specialists as to their participation on the overall health team for an individual. Clearly, care coordination comes front and center there, and we're talking care coordination primarily between specialists and PCP that also involve the patient. The second area that we talked about last call was managing specialty populations, and that puts the registries on the table, and how can we help specialists both generate new knowledge about their specialty, provide new evidence, as well as assess how they're doing in their current practice. That's the registry concept through managing populations. We also talked about getting experience from the field as part of that hearing date.

With that refresh on where we left off last time, any comments about those topic areas? We can progress the conversation on to panelists and questions, etc.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I don't know if we folded this into the second bundle of managing populations, I guess we could. You called out registries, but the clinical decision support category guidelines, application and that sort of thing, do you intend that to be in the same bucket as the managing population?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think so. That's part of the knowledge generation in the sense of there's a chicken and egg kind of thing. You want to know more and more about what works and what you need to know, the gap, and you get that through this population data and that feeds into the clinical decision, the guidelines, and then implemented through clinical decision support. Does that make sense?

David Lansky – Pacific Business Group on Health – President & CEO
I guess from a data flow point of view I was hearing, the registry concept , the way you sketched it seems as much about reporting out to registries and getting some aggregate feedback back, as distinct from having a rules ... somewhere and populating it with specialty ... or other guidelines. Which are then driving a clinical decision support application, which might in turn become something that drives a quality measure.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think we should have some discussion about decision support that goes beyond the registry part of things.

David Lansky – Pacific Business Group on Health – President & CEO
So, David, you think keeping it as a third grouping for the moment?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
That's what I would suggest.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, that feels right to me.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We had talked about having two care coordination panels and one population panel, so we can divide it up and we can rearrange as we see fit.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Along those lines, maybe there's a practice side, meaning delivery of care to individuals, and one aspect of that is the care coordination amongst the whole team, and another aspect is decision support within specialties. Is that how that might ... out?

W
I think that's a good way to frame it.

Christine Bechtel – National Partnership for Women & Families – VP
I like the idea of hearing from a primary care provider, a specialist and a patient on the same panel who would talk about care coordination and what they need to really make progress across I think the three different areas that we've been considering for the last several months. So it's both the functionalities of the technology that they really need, the great hearing that David Bates co-chaired when we talked about just even having a list of who's on the care team, some things like that. So asking them to think about the functionalities but also asking them to think about the quality measures and the role of the patient in providing both feedback about the process but also using the technology and their role in care coordination. It might be neat to have a panel of people who actually work together in the real world, a patient and two docs who do coordinate, and what they need from a functional quality and patient feedback perspective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's exactly our intent when we created this topic 1A, it's the whole care coordination and let's look at it from the whole team, including the patient, and what it is they need to ensure that the care is coordinated. So that was a good re-articulation of that, the thought behind that one anyway.

Christine Bechtel – National Partnership for Women & Families – VP
Maybe I missed that call, sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No problem. It's been a while. Other comments on those topic areas? Let me re-enumerate those—

David Lansky – Pacific Business Group on Health – President & CEO
Yes, that would be good, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The first deals with care coordination, that includes the specialist, the primary care provider, and the patient, and how can we ensure that that happens effectively, including its measurement at the QM side of it. The second part of that ... is how do we support the practice by specialist with individual patients and that's where the clinical decision support comes in, meeting their needs there. The third one is how do we leverage population data. Registries is an example, but there are other ways of managing the specialty population and both understanding what we do and understanding the gaps and driving new knowledge. Then we had a fourth panel on experience from the field. Are we on the right track with those four panels from this hearing?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
In that first panel on the care coordination piece, I think this is where last time we discussed potentially having someone from care management be on that panel from the nursing perspective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, okay. I think that's going to be a really neat panel.

David Lansky – Pacific Business Group on Health – President & CEO
Let me ask, an issue, I don't know quite where to put it, in terms of back to the health reform discussion and payment reform in particular. Part of the expectation is that the data infrastructure will support new payment models, which are very difficult to implement now, including episode payment in this context, where we're bundling a bunch of services from a bunch of providers together. Then capturing the clinical data, both for care management but also for payment and accountability and reporting and hearing and all the other stuff. I'm wondering where we would fold in a prospective, maybe from CMS or from a private payer or from an ACO builder, somebody who's thinking about information requirements for those purposes coming out of the clinical data system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Interesting. Do you think that could fit into the population?

David Lansky – Pacific Business Group on Health – President & CEO
I think we could shoehorn it in there. It doesn't totally fit the way we articulated it, but it maybe goes there.

M
Actually, could you say again how that would fit in there, David?

David Lansky – Pacific Business Group on Health – President & CEO
Well, I was shoehorning it. I wasn't quite fitting it.

M
Give me the short title of it and then I can extrapolate.

David Lansky – Pacific Business Group on Health – President & CEO
Instead of leveraging population data, I would say generating and applying population level data or aggregate data.

M
So it's kind of 1A and 2.

David Lansky – Pacific Business Group on Health – President & CEO
I'm trying to get beyond the individual patient care scenario and think about the other uses that everyone is expecting—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exactly, I think it's ..., because the population management panel, because it's reuse of data because 1A includes data from patients and from doctors and in the population panels, we're using that data. So it's reusing both kinds of data, so of the three it fits probably best there.

David Lansky – Pacific Business Group on Health – President & CEO
I'm agreeing with Paul. I think in that context we'll also hear from people willy-nilly about the multiple reporting environment, including PQRS and others, and the issue of harmonization of all these reporting systems will come up somewhere, maybe in that third bucket.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We may want to make sure we get the right questions to ask and then we'll re-title and re-frame what that panel looks like, but I agree with you. As George described it, it's in the reuse kind of format, but it's not exactly registry or something .... So we'll get the right questions and then figure out how to label the panel.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I would like to hear from somebody who's doing all of this, maybe a couple of groups who are doing it all really well, who have moved down the medical neighborhood path and feel like they have an effective approach around that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder if that could fit in the experience on the field, so you're suggesting maybe a Beacon representative there?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I don't know if there's anybody from the Beacon program who's doing it well. If there is, that would be fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Art Davidson – Public Health Informatics at Denver Public Health – Director
David, when you say "doing it well" do you mean around this ACO approach that David Lansky's talking about?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Yes, although it wouldn't have to be exactly in that context, but that's certainly where things are headed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, I think actually we're making the transition into talking about questions for each of these panels. Should we move on to that? The first one, so called 1A, is care coordination. In this 1A panel, it's care coordination looking at the perspective of this multi-disciplinary team that includes the specialist, primary care provider, the patient, and the care manager. What questions do we want to ask of that panel?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's obvious what types of data are needed and when in the care process.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

By whom and when, right?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes. That may be too general, but what we need to figure out if we're going to actually turn these into objectives eventually.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think that the best work on this has been done by the people from the Center for Healthcare Change, who we had testify at the care coordination meeting. I was thinking maybe of having one of the practices that they studied come speak or something like that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we might be a little bit more directive in saying, give examples of the kinds of objectives and measurable criteria we might —

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I'm thinking particularly what does the record need to do for you to do this well?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Christine mentioned quality measures, so another kind of question is, and how would you assess how well this process is working and who would you ask that of?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I suppose you can ask that here. I don't think that there are any existing quality measures that are really good in this area.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP
I know. I agree. But I was at least thinking this is one place where asking patients or family members to give them feedback, at a minimum that providers can use that to improve and it also creates in patients an increasing expectation that the processes go smoothly and they can be part of fixing the problem. So I think, David, you're right, the existing measures as we learned in the work of the tiger teams and otherwise existing measures of care coordination, are maybe not ideal, but they're something. But asking for feedback on really what we should be measuring and then asking specifically about patient and family feedback could get us started in some thinking.

Neil Calman – Institute for Family Health – President & Cofounder
I think that in the care coordination piece one of the things that we talked about in the first hearing with specialists was the very granular aspects of how to define the information that gets passed back and forth so that it's most usable. I think that this is a huge issue in relationship to what we're going to call out for meaningful use criteria because in terms of where the content is going to get added so that people get the right amount of information. I mean, we heard that people don't want to be inundated with information at the point a specialist is seeing somebody who's had long-standing primary care, but then who determines where that information gets vetted so that they get an amount of information that's useful. I think that that's a really critical issue that we should try to get some input into. It's going to have to be different for every specialty area, so who's going to create the content that we're going to end up developing in that area.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I'm afraid the specialists will say it's the primary care doctors and we don't want to do that.

Neil Calman – Institute for Family Health – President & Cofounder
I think it is in a way. Somebody's going to have to say here's what information is relevant in a referral to a dermatologist versus referral to a cardiologist versus referral for somebody who's going in for major surgery, and having everything presented to the specialist in my mind means that they're not going to look at anything.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think that the first frontier is actually just getting something back and forth. The work that we—

Neil Calman – Institute for Family Health – President & Cofounder
We're dealing with that already.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
No, but Neil what we found was, when we studied the referrals here 50% of the time the specialists had no information whatsoever and they didn't know what the primary care doctor's question was. In addition, 50% of the time no information went back to the primary care provider. If we just deal with those things, I think we'll be a long ways down the road. Our experience has been, in building an application to do this we built this very complex thing that tried to do what you're describing and nobody used it. Yet it's obvious that there's this very big problem of just basically nothing going back and forth.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the things we talked about in stage one was this whole round trip thing. There's no reason why that can't come back. I'm not even sure why it didn't get in the first time. Maybe it's because it's too much HIE.

M
Paul, can you just clarify what you mean?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In stage one, we talked about after our specialist panel that this subject came up, what David just mentioned, about specialists would love to have the reason for referral. PCPs would love to have the result of the consultation and just that, one, the fact that it happens, and two, the turnaround time would be very helpful for both sides.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
For this stage, I'd be delighted if we got that far.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
From the work that we've done on this stuff, getting back a note that says "Here's what I saw" without any recommendations for treatment and things like that that require specialists to do something different in a note that is going back to a primary care provider than something that they would use to document in their own record, is critical. So how we would put that out I think remains to be determined, but the documentation for one's own use is very different than the way one documents. That's why you don't get the question passed over that says, "Here's what I'd like you to do, Dr. Cardiologist." You just get a note of what's there. It's why the cardiologist says, "Here's what I found," but doesn't say, "Here's what my recommendations are for follow up and treatment." So I think that's an important piece to be called out here, but if we're happy just passing a summary back and forth, I don't think we're going to get where we need to be in terms of real communication between providers.

M
I think, Paul, I'd like to amend my—what I really meant is what the minimum types of data are needed to be transferred and seen by whom and when. In other words, it's easy to sit there and come up with a wish list of everything I might want to know in the next three years about any of my patients. It's harder to

say here's what I need every time and we should start with this. It's kind of the starting set of what needs to be transferred, not to dumb it down because of the reasons Neil said.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Neil's requests are reasonable, what do I think and what do I recommend should be done, but my point is just we should try not to get too elaborate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's George's counsel, if we frame it in what's the minimum and we've done this before, we gave a list of things that should be in a "clinical summary." So if we can come up with something, and it can be fairly minimalistic, but you've got to know why you're referring this and what did you find and what do you want me to do, and that kind of thing. So we probably can come up with a short list.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
That would be a good question.

M
That would be helpful.

Jim Figge – NY State DoH – Medical Director
This is Jim. I have a suggestion. There are some active projects going on now with NHIN Direct. In particular, the MedAllies project in the Hudson Valley of New York is doing exactly what you guys are talking about, a referral from PCP to specialist, and then data back, specialist back to the PCP. It might be useful to talk to people in that project and other similar ones in NHIN Direct to see how they're doing this, because I suspect that a lot of this work has already been done.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a great suggestion. So, we can put that on the list of candidate panelists. Other questions for this panel? I think we'll have a very meaty discussion just getting the different perspectives on what's the data needed to enhance care coordination.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, let me just read off my notes from our last meeting to make sure we're not missing one. Data exchange and referral loop, longitudinal data capture, patient reported outcomes, registries, longitudinal care plans, problem list reconciliation, med reconciliation, and how are the above operationalized for their specialty. That was our list for care coordination.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We had some good ideas back then too. I think we'll take the discussion from the list that George just read off plus what we've added here and come up with some questions to circulate in e-mails. I want to move on to Panel 1B, which is support of specialists caring for individual patients, and to include clinical decision support. So questions to ask the panel?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Something about what clinical decision support is relevant to your specialty.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I think there's kind of a ... question that we make, I don't know how to get at it, but to ask the specialists if they think about their own professional standards or directions. What do they think is a reasonable expectation for the adoption of both clinical decision support as functionality in the EHR but also in a sense the uniformity of the rules that drive it? What I'm probably getting at, as we think about meaningful use and how we want to articulate the criteria, is there a consensus or some understanding among the leaders. That there should be adoption in clinical IT systems of professionally defined

guidelines or standards, or just what's the mechanism we should be thinking about as the fuel for the clinical decision support enterprise.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That sounds like a knowledge management kind of question. You have to start with uniformity of guidelines, which isn't trivial, and then move on to how you implement in EHRs ....

David Lansky – Pacific Business Group on Health – President & CEO
Yes, is that basically an ad hoc and local process, or is it one that has national uniformity and we should be encouraging it through the discipline of the meaningful use program?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other questions? The third panel was on use of population data, which could include registries.

David Lansky – Pacific Business Group on Health – President & CEO
I think we want to hear about best practices in terms of the feedback from ... the populating of registries and the feedback from registries for improvement or other purposes. I think there is this question of how the registries are being used to support CMS and other reporting programs, which is obviously a part of the CMS program, but we want to have alignment between whatever we're recommending and what they feel there's value in doing for their other purposes like PQRS.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So your first idea, the feedback, I'm trying to think what we didn't hear about in the first specialty hearing. One is having feedback that comes back to influencing individual care. Is that what you meant by your first topic?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, and also program management within the institution or within the practice, not just individual care. I've certainly heard plenty of stories of people who feel like they discovered their program as a whole has got a higher complication rate than somebody else or worse outcomes than somebody else and they get motivated to do improvements because they see the benchmarking data.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think some of that is about the timing of when that feedback comes. If it's about a patient who's being seen, does the registry that services the needs of the specialty have that capability of feeding back to the EHR at the time of care?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This panel is perhaps the last panel, this is an area where we get lots of feedback on the barriers of the infrastructure and how hard it is to have consistency, so I think there's a lot of variation here still, so again, some comment about what are the barriers to achieving their goals considering the public health infrastructure.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
And how might they be overcome.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
One of those to note, Paul, is there's an audit discussion in California about HIPAA misunderstanding or accurate understanding of HIPAA as a barrier to participation in those registries.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think that's good.

M
Another one, David, might be how do we stimulate and ... more quality measures for specialists, so that's basically a use of population data.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, definitely.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I just want to go back to what Charlene was saying. You mentioned, Charlene, about the public health infrastructure. At this point, I think we're talking about the specialties and their use registries for population data, so I'm not sure if it's about public health infrastructure or the specialty's ability to use registries effectively for populations.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay, that's fine.

Art Davidson – Public Health Informatics at Denver Public Health – Director
We could extend into a public health infrastructure discussion, but I don't know if that was the intent of this panel.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay, but I still think even on that line then, getting the data back to the EHRs and those types of things are relevant.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right, absolutely.

Jim Figge – NY State DoH – Medical Director
I just wondered if we might want to call out specific examples of registries where there's a good evidence base. One example might be with patients with diabetes where there's published literature showing that use of registries can greatly facilitate improvement in care and outcomes. So I don't know if it's worth looking at the evidence and calling out specific areas where we know that the use of a registry will actually improve care.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think, going back to something that David said earlier, where the decision support lives in the registry, and Jim's recent comment, the examples from immunization registries and improvements in immunization rates, a lot of that decision support lives at the registry level, not in the EHR. So there may be some models, like Jim is saying, that we could look at as successful methods to improve outcomes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
It varies quite a bit from situation to situation, but yes. There are different organizational approaches, but that's one of the key questions is where should all this stuff sit.

Jim Figge – NY State DoH – Medical Director
I think we need to use some creativity and flexibility. I think some of the functionality could exist even on a health information exchange. For example, with the diabetes model different pieces of information might be in EHRs of different physicians, like the ophthalmologist may have an eye exam, the endocrinologist may have the most recent A1C, etc. With an HIE model where some of the functionality resides, you can pull all that data together and build the registry in a more central fashion without having it reside in each individual EHR. I think we might want to be flexible and look at some models like that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A huge topic here. If there's one word it's more "infrastructure," how do you get information in, how do you normalize, how do you authenticate both the patient and the provider, what are the privacy implications, that was the HIPAA misunderstanding. Something that came up at our first hearing is and what about the proprietary nature of some of these registries, and then how do we get it back out to influence either practice programs, as David Lansky was saying, or individual care, a huge area.

Jim Figge – NY State DoH – Medical Director
This is probably something we have to tackle if we're going to move in the direction of ACOs, because you're going to have to have a model like this for an ACO to work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so we'll have to be careful and try to figure out how to phrase some of these questions and tease out some of these issues.

M
Talking of ACOs, this is going to get mucked up in the whole area of attribution and responsibility. Who's really responsible for making sure this stuff happens. But I think the idea of figuring out how the information gets passed back and forth so that everybody that needs it has access to the full scope of what's going on with the patient is critical.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's probably where we need to limit ourselves because attribution, as an example, is a policy area that's unfortunately outside of our scope.

M
Right, but it's why we need to know this stuff.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I just want to let you know that I joined. I just got out of jury duty. Sorry for being late.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks, Michael. Anything more on this particular panel? Okay, let's move on to, we sort of called out experience from the field and one of the topics that David Bates mentioned was learnings of folks implementing things like medical home, medical neighborhood, advanced places where this is starting to work. Another area we wanted to do is draw on the RECs, right?

W
I think so.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Anything else?

Marty Fattig – Nemaha County Hospital – CEO
This is where that information from the various groups could come in, anybody that surveys their members.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
I think one of the things that I'm interested to know is how this is really playing out operationally from the perspective of—and I think the RECs could help with this—the workflow changes that have to happen.

Because that's really, in my mind anyway, a lot of the bottom line is how workflow changes to provide more patient centered care. So it would be helpful to understand if there's a mismatch between what we were trying to accomplish with the criteria or functionality, and how that functionality is or isn't really being used in practice or if it's meaningful or not to patients. Because of the way that it's being—because I was thinking about something I heard Neil Calman talk about, which was the difference between handing a patient a visit summary and having them walk out the door and not talking about it, and talking about it with them and finding out that it's really meaningful. So I don't know if we're starting to see some of those lessons yet, but I think that would be helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In some cases a little bit either unintended effects or unintended workarounds.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I would like to hear from some actual providers in this group, either from a specialist who has tried to adopt or I guess from a specialist within a hospital.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. That topic brings up one of the questions we've been hearing about is the category specialist where it seems less relevant. Talking about primary care, it seems that we've had a lot of focus and we had the broad category specialists, and they're folks like radiologists and pathologists who potentially are eligible, but how do they participate I think is one of the questions they posed to us.

M
I think we should make sure that we include something on behavioral health. Because there's such a huge emphasis on the coordination now between behavioral health and primary care, that it would be good to think about that throughout all these panels to make sure that we're not thinking about medical specialties, but also thinking about behavioral health specialty and coordination.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Could that fit up in, we could call it specialist CDS, but I wonder if the broader category is EHR support of individual care by specialists. Does that make sense? That's a bit broader. I'm not sure we had a whole lot of questions up there, but maybe that helps broaden that category and allows us to include things like this.

W
That would make sense to me.

Jim Figge – NY State DoH – Medical Director
I think also in the care coordination piece, you were talking about the second part, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Jim Figge – NY State DoH – Medical Director
Yes, but I'm thinking also in terms of care coordination piece and also in terms of the experiencing, I think it's where people are beginning to do a lot of work about in terms of coordinating care between behavioral health and primary care. So it could fit into a number of different categories.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was looking at openings too. Our first panel probably had the biggest number of folks. Should we go back to this and try and get some names or organizations that make sense? The first one is that care coordination, and the kinds of folks we included were specialists, it's hard to represent an entire group with one person, but specialists, primary care, consumer patients, care management functions. Marty, I

think it was, mentioned the MedAllies in New York in terms of how do you get this minimum data set data to go back and forth. Is that where that applies, Marty?

Marty Fattig – Nemaha County Hospital – CEO
It wasn't me that made the comment, but I do remember hearing it, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I mislabeled that.

M
It was Jim. I think he meant the ....

Jim Figge – NY State DoH – Medical Director
Yes, that would be like John Blair at MedAllies.

W
It might be interesting to ask John to have one of his primary care providers and a patient they share in common, so it's like really specific to a real life situation, if that makes sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not sure we want to use all the slots with one group, though, right?

W
Yes, but I think what we're looking for is real world field experience and it's hard for me not to imagine going to only one group as opposed to organized medicine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I wonder if another place where this could come in is the experience from the field, and that's an interesting way to look at it. So we'll keep a placeholder in both places.

M
Are we talking about people representing the various provider organizations here, because that's what we did the last time?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think it's real life, so I think people with real life stories would be helpful.

M
Yes, I do too, because I think the associations have limited contribution except to say what were some big picture things that they knew about, and the people who were most informative in that panel, in my recollection, were the people who were actually both representing associations but were also providers who were doing stuff with it.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I agree. I think we have a responsibility not to recommend policy based on an … of one, but I think we'll do that later and we'll understand if this is more widespread. But we did just hear from organized medicine through the comment process in a very robust way, so I like the idea of all the panels really focusing on real people who are doing this in the field and then we can get more input as we go forward.

M
Well, the team could be one presenter. In other words, it doesn't have to be three out of four in the panelists are from one team, you can have all three people show up and have one of them represent the group, but have all of them there to answer questions. We could do something like that to save time and open the representativeness of it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Do we have other examples of where some of this is moving and in particular focusing on care coordination, where they could speak from real experience?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think Geisinger is doing some good work around this, so Tom Groff would be a good person to ask. As I mentioned earlier, I considered talking to somebody from the Center of Healthcare System Change, like Ann O'Malley, to see if there's someone that they talk to who is especially good at this, that they would suggest.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We heard from here before, correct?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
We heard from her. She talked about the meta results here. I'm talking about somebody that they actually interviewed, because they were in a whole bunch of practices for a while around exactly this topic.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Any folks who are like Ann, a pointer to people really doing it and to explain some of the benefits but also some of the considerations?

Marty Fattig – Nemaha County Hospital – CEO
A couple that I've heard of that are doing a good job, one is Denver Health and the other is Intermountain.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other names or organizations that can point us to ground level folks?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Are you still on the specialists?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The care coordination panel.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, I don't know what our position is. I think Geisinger is a good example of getting a case manager. There's also a coalition, that's the National Transitions of Care, care management society, but it's an association and there's the executive director of that who can also speak, is another name, but again, it's not as operational.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
One more thought is that Group Health has done some interesting stuff with enabling eConsults. I think we tried to get somebody from there for the last panel and I was unsuccessful. They canceled.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, perhaps David Stevens at the National Association of Community Health Centers could point to some good safety net providers who are doing this care coordination. It would be good to hear from them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Like Group Health, Kaiser has certainly been doing things with both team and electronic communications.

David Lansky – Pacific Business Group on Health – President & CEO
I think we should try to find a network that's more of an IPA or an open environment where they're using the tools for virtual coordination. I don't know the details, but we might want to check in with that

Sacramento program with CHW, Hill and BlueShield, where they're doing kind of a virtual ACO and I think it's an IPA based model. I think they use NextGen. I don't know what they're doing for their integration.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And that was in combination with BlueShield or something?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, it was.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I wasn't sure if I spoke with my mute button on or not. Did you hear what I said about the National Association of Community Health Centers?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Michael Barr – American College of Physicians – Vice President, PA&I
Okay, thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, we've got some good leads there. How about the next panel, which is the EHR support of specialty care for individuals? We talked about CDS, we talked about guidelines and uniformity of guidelines, and we talked about behavioral and another category is non-direct providers.

M
There are two people who would be good. One would be Eric Schneider, who's done a lot of work in, he's actually a primary care doctor, but he's done a lot of work in specialty guidelines. Another person would be Karen Kmetik from AMA. I'd have one or the other of them. Karen really runs their guidelines program.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, the PCPI.

W
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
I know, Paul, we had had an exchange, I think you and I and Josh a while ago, a couple of societies like ASCO that had subcommittees doing work on specialty EHR products and their applications to that specialty. I think pediatrics did, the oncologists did. Another thought is, if we're talking about Intermountain, Fred James had been doing some work on cancer EHR functionality. I don't know where that is now, but he might be a good contact into that world.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we heard from ASCO actually at the last specialty hearing. I wonder if other groups that are under-represented, like ... might be an example, but along those lines we did hear from ASCO last time.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Karen may know in each of the specialty societies who's done the most work on EHR applications and functions for their area, and where the value proposition has been greatest, or ADMS, someone there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let's see, behavioral work, that's you, Neil. Do you have any suggestions there?

Neil Calman – Institute for Family Health – President & Cofounder
I can talk to a couple of people. I know that the behavioral health folks in our organization are working on this, but I don't know to the extent to which they're working on decision support.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's basically EHR support of specialty care, to broaden it.

Neil Calman – Institute for Family Health – President & Cofounder
I can get in touch with them. They've done a tremendous amount of work in building interview forums and other stuff in mental health in a way that's accessible to both primary care and also to the behavioral health folks. We're also working with a group from Mount Sinai that's just implementing their programs but are involved in this as well, and I can speak with them, or put you in touch with them, better off.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
.... Other suggestions?

Neil Calman – Institute for Family Health – President & Cofounder
I can get the names of some other folks too. I know that they've been in touch with people around the country who are doing EHR support for mental health, so I can try to forward to Josh the names of some people to contact.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. As far as the providers who don't have direct contact with patients and getting that kind of perspective, we can look to some of the folks that have been commenting in the imaging space and the pathology, other providers who might be EPs, but to which our current criteria may not apply especially well.

Any other suggestions in this area? How about the population data area? It's really how to get it to come together. It is one of the outputs of the MU program, but there are so many barriers and challenges and how do we both understand them and work at a policy level to try to overcome some of these.

W
Is this where you would actually want to use an association, in this particular one, since it's more policy comments?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
To the extent possible, it's always better to have people who have either done it or are doing it. I guess preferred is done it. One area would be Marc Overhage with IHI.

M
He's moved on. He's now—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I know. Or …—

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... talk about this—

W

He's not going to have forgotten that soon.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I don't think he's going to forget.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Now the question will be just whether he wants to do this kind of stuff.

W
Yes.

Deven McGraw – Center for Democracy & Technology – Director
It's also if we want to hear from IHI we should get someone from IHI.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, Rick Gliklich from Outcome Sciences, they've been a vendor to AHRQ, they've been in the two big report AHRQ reports on registries, and they've got a canvass of really the whole country's registry environment and what the barriers and opportunities have been in those two reports for AHRQ. That might be a good overview of what the state of the art is and where the barriers are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That would be good.

David Lansky – Pacific Business Group on Health – President & CEO
Especially if we focused among our particular interests here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

M
So our goal is to engage specialists. We got here from specialists, we don't want to just, and most of the ideas I'm just repeating our registries panel, so I'm trying to think of what accomplishes the goal specifically to engage—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think we want a specialist who actually tries to work with one of these entities on a regular basis.

M
Yes.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
You're not excited about that?

M
I'm actually trying to find someone on the ground, so I'm agreeing with you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Also, we did hear from specialties, like STS I think we heard from. And if we take—

M
... overlap with the previous one, but still—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. If we take a policy level approach and try to generalize so that we can come back to and what is it that to the meaningful use program we can incent the EHR vendors as well as the providers who use these things, to contribute to the population data. Some of it can feed to us and some could be to the

NHIN workgroup of the Policy Committee and it could be to the ... a lot of infrastructural barriers over meaning.

M
Okay, but even if this panel becomes a little bit more policy focused, I want at least one person on the ground.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Oh yes. Hopefully there are people who are on the ground who now better understand the policy implications and how it can be helped.

David Lansky – Pacific Business Group on Health – President & CEO
I know some of the specialty areas better than others, people like Jim Weinstein from Dartmouth, who's a spine surgeon and also he's a senior physician at Dartmouth, plus he's been driving a lot of the adoption of the registry strategy nationally, so you can talk about the Dartmouth experience in applying population level data to practice.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think he'd be great.

David Lansky – Pacific Business Group on Health – President & CEO
There are a couple of other people, Kristy Weber, who's an orthopedic oncologist, the orthopedists have started a new quality institute where they've decided as a specialty to produce both guidelines, performance measures, and appropriateness criteria. So that's in the same specialty area, but I think that's more of a policy strategy for using registry data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
When you went to Dartmouth ... thought about Elliott Fisher and thinking about this kind of support for ... ACOs, presumably, the NPRM will be out and just to reflect on how can we build meaningful use to support that whole need.

Any other? Okay, the experience from the field panel? What folks would you think about, Josh, in terms of the RECs or survey folks, who could help better understand what's happening out in the field?

Josh Seidman – ONC
There definitely are some RECs, they're working with both specialists and primary care physicians and so we can certainly have our meaningful use community practice discuss that. I would also suggest the Beacon, you can talk to the Beacon program and find out if there are people who they would suggest.

Deven McGraw – Center for Democracy & Technology – Director
Do we feel like we've heard enough in some of the testimony that we've gathered in many hearings that we've had from pediatricians on this issue? Because there's such an important Medicaid population and I know I certainly have heard from them about concerns that we've focused a little too much on adults.

M
Yes, I think that there are some important pediatric issues. I was also going to mention that there's a project that CMS and AHRQ are doing on developing a model children's EHR format and so they're moving along in that process and defining what are the requirements that will be required to ensure that the data that is necessary for pediatricians to use, so that might be something—

M
Would that be up in panel two then—

M
I was going to mention it when someone brought up pediatricians in panel two—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's not well covered by our functionality and, as you mentioned, Medicaid that's the ... special application.

M
Kevin Johnson is one obvious person to talk to.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Another IPA, Taconic, is rolling out one of those virtual ACOs, doing a lot of care coordination and I'm sure interfacing a lot with specialists and primary care doctors, so they may be another source. Dr. John Blair and Dr. Holly Miller are involved in that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, we also had them as a possibility up in panel one, but I think that that is so crowded, so this might be a good place to—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

M
Paul, what was the original intent to this, a specialist panel on experience from the field, or was this experience from the field and we needed to put it somewhere so we appended it to the specialist ...?

M
I think it's the latter. It depends on what question we're asking, or what question we want to answer. Like, say Beacon community would be an example of someone who's been doing it for 20 years and has $20 million, how is meaningful use ... different than, but then just going to someone who's never heard of an electronic health record and sticking them on a panel is not going to be very useful to us either. So where is the point where there's the most information to be gained? So is that someone who tried and failed, do we get that from the REC? Is it because they did something wrong? I don't know what it is, but it depends on what information we're looking for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's the how's it going, what are you finding, and that's where the RECs come into play. As you spoke about it, the New York experience might be informative as well, because they already had, they're a little bit of the progenitor of the RECs, they had this local community IPA kind of experience, and maybe hearing from them would be useful.

David Lansky – Pacific Business Group on Health – President & CEO
Amanda Parsons would be great, but again, she's someone who's been doing it, so we have the successful ones and then we have something that's not less successful but just earlier in the stage.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're ... in lessons learned, so that some of these folks who have already been doing it and doing it ... could be useful.

Marty Fattig – Nemaha County Hospital – CEO

I'd just like to make sure that the rural voice is heard, and that may come through the RECs, but I would like to make sure that they're heard.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I agree. If possible, I'd rather have it not just be through the RECs. The ones that I am familiar with filter things and you tend to hear mostly their success stories.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. There's a built in .... We can ask HRSA, as an example, to point ....

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I always thought that David Stevens could be helpful here too.

M
I'm sure I could get you some names as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, good. I think the homework to do is to summarize and categorize some of these questions and candidates for these four panels. Is that something you'll work on, Josh?

Josh Seidman – ONC
Sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And we can then try to iterate on that over e-mail. Again, I think we're going to need another call unrelated to the April 5th so that we can finalize our specialist panel.

Judy Sparrow – Office of the National Coordinator – Executive Director
I'll send you around a few dates.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great, thanks. Okay, anything else here before we move on to public comment? Okay, to summarize from today's call, we had a good opening discussion about timing and timelines. I think it's something we all want to really think about, both what kinds of options we may have and then incorporate that into our thinking as we receive the information from the RFC in about probably a week, and make sure that we have read that material before coming in to April 5th.

Our goal really is to look at the entire package. I think we'll focus in on the categories, the objectives, and criteria, and use the flexibility options we have as far as how to look at timing in that context. Or vice versa, look at the existing and new functionality in the context of timing and hopefully come out with a good framework for how we structure our draft recommendations for stage two and in particular the kinds of timing options. The reason I keep coming back to that is at the April HIT Policy Committee meeting it would be good for us to talk about the whole timing as well as some high-level things and functionality. But we won't be really going down to each category and each objective until the May meeting for the HIT Policy Committee. Then we talked about specialty hearings and the four panels. We've identified some questions and scheduled candidates for panelists that we'll circulate by e-mail, and then we'll re-discuss at our next call. Any additions to that?

David Lansky – Pacific Business Group on Health – President & CEO
It sounds good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so we can go on to public comment, please.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you please check and see if anybody wishes to make a public comment?

Operator
We do have public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Please identify yourself.

Chantel Worzala – American Hospital Association – Sr. Associate Dir. of Policy
Hi, this is Chantel Worzala at the American Hospital Association. Thanks so much for another engaging discussion. I really appreciate the consideration you're giving to the timing issues because they are quite challenging for providers. As you think that through and look at your various options, I do want to make sure you understand that the penalties that begin in 2015 do speak very loudly. I think an approach that ensures as many folks as possible get on that first step of the escalator before it starts to rise rapidly will, in fact, get us where we all want to be. Which is to have everybody using electronic health records in a way that makes it possible to share information for care coordination to support health reform, etc., so remember when the positive incentives run out, you do still have a very strong motivator down the road.

I also just wanted to reconfirm our availability to provide any input that is helpful to you. The American Hospital Association did survey its members in January 2011 on progress in meeting the stage one objectives, and saw very, very strong interest, 95% of hospitals plan to pursue meaningful use. But at that moment in time asking about each objective separately, both the functional objective and the certification requirements, we only had 1.6% of all hospitals and 0.8% of rural hospitals that could say they could meet all of the requirements in the final rules as of January 2011. So we're happy to provide both that kind of input and also help you identify individual folks who have very important lessons and experiences to relate. Again, thank you, and I think Josh knows how to find me. Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Chantel. Any other comments?

Operator
Our next comment comes from Julie Cantor-Weinberg.

Julie Cantor-Weinberg – College of American Pathologists – Dir., Public Health & Scientific Affairs
Good morning. This is Julie Cantor-Weinberg with the American College of Pathologists. I very much appreciate your willingness to have a hearing on specialists, but particularly for pathologists and other physicians perhaps like radiologists, who may have less direct patient contact, we found most of the meaningful use requirements both in stage one and the anticipated ones for stage two to be very much a square peg, round hole problem. Obviously, 70% of the data in medical records comes from laboratories and pathologists who run them, and with the advent of genomic medicine our members' role in test selection and therapy management will become more important. It's not clear to me that the design of the hearing gets at the challenges that specialties who have unique scopes of practice, interactions with patients, and kinds of medical records ... will be teased out. Thank you very much.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Julie. Do we have any other comments?

Operator
Yes, we do. We have Keith Dreyer.

Keith Dreyer – Massachusetts General Hospital – Vice Chairman, Radiology Informatics
Good afternoon. My name is Keith Dreyer. I'm the Vice Chairman of Radiology at Massachusetts General Hospital at Harvard Medical School. However, today I'm speaking as the co-chairman of the American College of Radiology's IT and Informatics Committee. The ACR is a professional organization representing over 34,000 radiologists and radiation oncologists.

First of all, I wanted to express that this working group has made significant progress in a short period of time developing preliminary recommendations for stage two. However, the College feels that there are some gaps in your draft recommendations, not only for specialists like radiologists, but more importantly for the patients we all serve. As we estimate over 90% of all U.S. radiologists will now be considered eligible as EPs in the program, the ACR has been very active in corresponding both with the ONC and CMS, and has most recently submitted a response to your working group's recent request for comments calling for the following items.

One, that diagnostic images and related data such as structured radiology reports, imaging history, and radiation dose data be accessible via EHR technology. EHR radiation integration of medical images is easily technically achievable today, as demonstrated by hundreds of medical centers, and it is not university adopted and should be. There should be specialty specific pathways to MU and stage two. For example, it makes more sense from a care coordination perspective that radiologist EPs be required to make schedule options available, receive electronic orders, develop structured reports in a timely fashion, provide Web-based access to images and reports via EHRs and PHRs, and to adhere to standards of medical image archiving, access and display set forth by the national organizations.

Three, in lieu of specialty specific pathways exclusion from individual objectives measures must be flexible, plentiful, and scope based as they have been in stage one. What makes sense for primary care and PCP like specialties, does not usually make sense for specialists with unique workflows and HIT requirements, such as the previous caller with pathology and also radiology. Next, to manage the inappropriate use of medical imaging and its often associated ionizing radiation, the bar should be raised in terms of CPOE for medical imaging, with included clinical decision support tied to well established, appropriateness guidelines set forth by national organizations. As just an example of this, the American College of Radiology has been providing hundreds of nationally available transparent guidelines and clinical decision support for appropriate ordering since the early 1990s.

Next and finally, EPs should only be required to implement those certified EHR models that they actively use. Radiologists need risk pack products to adequately do our job. Risk packs can achieve certification for many criteria we need for compliance with the CMS regulations. We do not have a need for ePrescribing, CPOE, immunization registry communications, and other such technologies that correspond with MU measures, which we will likely be excluded from. ONC regulations currently, however, require that EPs implement these technologies regardless of exclusion. This is a huge compliance barrier for us and it discourages our radiology IT vendors from seeking EHR module certification for products that we currently use. If you have any specific questions, the ACR is always available and willing to help. Thank you for your time and convenience.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Dr. Dreyer. Do we have any other comments?

Operator
Yes, we have Mike Balka.

Mike Balka – MERA Hospital, Madison, Wisconsin – Meaningful Use Project Manager
This is Mike Balka. I'm the Meaningful Use Project Manager at MERA Hospital in Madison, Wisconsin. In regards to the stage two timing options discussed in the first part of the meeting, it might just be worth noting that hospitals that are ready to attest for stage one in 2011 have to submit by November 30, 2011, but most likely will not take on that risk unless they know whether or not new functionality and hence upgrades would be required for stage two. So another parameter to play with might be tweaking that attestation deadline if it's not possible to know that requirement functionality for stage two. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Any other callers?

Operator
Yes, we have Terri Shaw.

Terri Shaw – Children's Partnership – Deputy Director
Hi. This is Terri Shaw. I'm the Deputy Director with the Children's Partnership. Thank you all for the conversation today and for serving on the workgroup. It's great conversation, and great progress is being made. I particularly want to thank you for your discussion on ensuring that you are gaining input from the field of pediatrics and from providers who serve the Medicaid population as you continue to look at specialty issues. I agree that the link to the model EHR format would be a positive way to proceed on that front.

On the issue of the timeline discussion, as you're considering your options there I appreciate the thoughtful discussion and I really would encourage you to ensure that whatever you do in this area for the stage two criteria you do make sure that you are really making strong advances for patients and families directly, not just the other providers. So some of the criteria around, for example, viewing and downloading data are really important for that patient engagement function and the ability to bring that patient centered care model to the forefront. So as you're looking at considering different timing options, just make sure that the progress that we're making for patients and families in particular is at the forefront and that we make real progress in that area and don't compromise on that in the interest of accommodating needs for flexibility. Thank you.

Operator
Our next comment comes from Marie Johnson.

Marie Johnson – AMA
Hi, this is Marie with the AMA. I just wanted to reiterate our previous offer. The AMA is here to help in any way possible and if you're looking for speakers, including small practitioners with boots on the ground, we have access to those contacts and also to Karen Kmetik. We appreciate you considering her. So please use us as a resource. We also want to continue to urge the maximum amount of flexibility with respect to the stage two requirements, including core menu and exceptions which will allow flexibility for not only specialists but also for primary care. Thank you.

Operator
Richard Eaton is our next comment. Please proceed.

Richard Eaton – Medical Imaging & Technology Alliance – Industry Manager
Thank you, the Meaningful Use Workgroup, for taking my comment today. I want to reiterate in part what was said by Dr. Dreyer about radiology and access to images and imaging information. As just one example, imaging information is not only critical to clinical practice but also to care coordination. MITA is here as a resource and I'm hoping that at this meeting and subsequent meetings that you will be able to utilize the expertise and experience that we have in terms of meaningful use and also communication of images and imaging information. We have I think a lot of resources to give you and I am hoping that we can have a panel which would include imaging people who have experience in the deployment, implementation and testing of the DICOM standard, which is critical to communicating imaging information. So we want to act as your resource and we would like to have a panel in which we can explain how we can help achieve the Nationwide Health Information Network. Thank you.

Operator
We have no more public comment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you very much to the members of the public who provided additional input, and thanks to the workgroup members and the ONC staff for another great call and productive session. We look forward to seeing everybody on April 5th.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks. Look out for the e-mails. Bye-bye.

Public Comment Received During the Meeting

1. Regarding David Lansky's comment about a panel to explore the other uses of meaningful use data, remember that several private sector payers announced in August of 2010 that they would be conforming their incentive payment systems to align with meaningful use criteria. The following is from the ONC blog entry of 08-03-2010: "Payers (Aetna, Highmark Blue Cross and Blue Shield, United Health Group, and WellPoint) announced plans for incentive programs that will work in parallel with the CMS program and utilize the meaningful use objectives."

2. Note: Industry Resource Constraint Issue - New functionality requires full development cycle to properly test which results in new base release requiring the industry to upgrade to the same levels of code all at one time. This is a Y2K type effort given the volume of work that will need to be done to upgrade systems.

3. The difference between stage 1 timeline and stage 2 is providers are locked into the program once they have attested to stage 1 therefore making the stage 2 timeline much more challenging. For example a provider could choose to delay their attestation until 2012 and still qualify for all incentives; if they fail to get to stage 2 by Oct. 1 2012 they forfeit Medicare payment.

4. Registration is not an direct indication of intent to attest. Several providers who are perhaps ready in 2011 are delaying to 2012 due to timing issue of Stage 2 final rule and compliance expectations.

5. Current certification covers all order types for CPOE.